



STUDENT INFORMATION FORM



LOCATION: Pershing Community Learning Center 2006-2007

STUDENT INFORMATION

CHILD'S FIRST AND LAST NAME: _____ STUDENT ID#: _____

☐ Male ☐ Female Age: _____ Grade: _____ Date of Birth: _____

ETHNICITY:

- ☐ Native American ☐ Euro American
☐ Asian American ☐ Hawaiian/Pacific Islander American
☐ African American ☐ Middle Eastern American
☐ Hispanic/Latino American ☐ Multi/Bi Ethnicity American

Other: _____

OTHER QUESTIONS:

- ☐ My child qualifies for free or reduced lunch
☐ My child is an English Language Learner
Native Lang _____
☐ My child receives special education
service s during school hours
☐ My child is new to this school

PROGRAM: ☐ AM only ☐ PM only ☐ AM & PM ☐ Kindergarten Wrap-Around ☐ Full Day Program/Other: _____

* FOR CLUB PARTICIPANTS ONLY AT COMMUNITY LEARNING CENTERS:

At the end of the club my youth will: ☐ be picked up by authorized escort ☐ go to the afterschool program ☐ walk home

MEDICAL INFORMATION/SPECIAL REQUESTS (IMPORTANT & REQUIRED): List any medical conditions, allergies to food/medications, special diets or any conditions that may affect your child's health while in the program, include any medications your child is taking or please indicate N/A if not applicable:

FAMILY INFORMATION

PARENTAL STATUS: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Re-married

CUSTODIAL & LEGAL GUARDIAN IS: ☐ Both Mother & Father ☐ Mother ☐ Father ☐ Other: _____

MOTHER/LEGAL GUARDIAN INFORMATION:

FIRST & LAST NAME: _____

HOME ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

EMPLOYER: _____ WORK PHONE: _____

E-MAIL ADDRESS: _____

FATHER/LEGAL GUARDIAN INFORMATION:

FIRST & LAST NAME: _____

HOME ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

EMPLOYER: _____ WORK PHONE: _____

E-MAIL ADDRESS: _____

Over for more required information ➔

EMERGENCY CONTACTS AND INFORMATION

EMERGENCY CONTACTS IN CASE OF EMERGENCY AND PARENT/GUARDIAN CANNOT BE REACHED:

NAME: _____ NAME: _____
RELATIONSHIP TO CHILD: _____ RELATIONSHIP TO CHILD: _____
HOME/CELL PHONE: _____ HOME/CELL PHONE: _____
WORK PHONE: _____ WORK PHONE: _____

AUTHORIZED ESCORTS OTHER THAN PARENT/GUARDIAN OR EMERGENCY CONTACTS: (N/A IF NOT APPLICABLE)

NAME: _____ PHONE: _____
NAME: _____ PHONE: _____

PARENT/GUARDIAN PARTICIPATION QUESTIONS

YOUR PARTICIPATION IS VALUED!

We are committed to providing a safe and stimulating environment for your child. Our programs depend upon the talents and resources from many in our community. Please check which of the following contributions you may be able to make.

- ☐ I would volunteer to assist with the daily program activities.
 - ☐ I would like to share my hobbies, interests and talents.
 - ☐ I would assist with food/snacks.
 - ☐ I would assist with recruitment of volunteers.
 - ☐ I would like to give a financial donation to support the CLC to assist low-income families' program fees.
 - ☐ My employer and/or company may be able to help financially or with donations.
 - ☐ I would like to participate on the School Neighborhood Advisory Committee.
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PERMISSION FORM

- ☐ YES ☐ NO I give staff permission to use photographs, writings, artwork, TV appearances, etc. for the promotional materials, presentations and documentary purposes.
- ☐ YES ☐ NO I give staff permission to transport my child for the purpose of program activities.
- ☐ YES ☐ NO I have received the program handbook.
- ☐ YES ☐ NO I give my permission for CLC staff to share and receive necessary information from all CLC partners to assist with providing the best program experience for my child.
- ☐ YES ☐ NO I give permission for the CLC lead agency to arrange for emergency treatment and to contact our family health care provider if guardian is unable to be reached and it is necessary to preserve the health of my child(ren) until such time then I/we can be present. I understand that no guarantees have been made to me as to the effect of such treatment on my child's condition. If necessary, the program will arrange for emergency transportation to the nearest emergency medical facility.

CHILD'S PHYSICIAN: _____ **PHONE:** _____

By signing below I give permission for my child to participate in program activities. I understand that the CLC does not carry health and accident insurance for my child/youth, and that I as guardian will be primarily responsible in case of injury where bills are incurred. As the parent/guardian, I will work as a partner with staff to ensure my child is successful in the program. I understand that my child may be dismissed for failure to follow rules, failure to follow general operating procedures of the program. The information I have listed is correct to the best of my knowledge and I will notify the program staff of any changes to the information in a timely manner.

SIGNATURE OF PARENT AND/OR GUARDIAN

DATE